Patient-link project

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SUMMARY: A teaching and learning project being carried out in the Department of Advanced Nursing Studies of the Welsh National School of Medicine is described which aims at integrating a number of concepts that provide the student with cognitive and social learning experiences. The core component of the project is the linking of a student to a person before he becomes a patient, so that the student is able to visit the patient in his home before and after his stay in hospital. Teaching and learning issues are explored which might or might not occur as a result of the introduction of this method.

AN increasing body of research literature points towards a close relationship between health, ill health, disease and social phenomena (Court Report 1976; M. Brennon, *et al.*, 1976). Though clinical evidence can be cited for effects of emotional states on physiological processes, (Boore, 1976: Hayward, 1976) the mechanisms involved are the subject of theoretical controversy. Nevertheless any health worker whose particular area of interest is concerned with the maintenance of health and the care of the sick can no longer afford to disregard this. Nurses are no exception. Therefore knowledge about a patient's social background and about the likely effect of social, political and economic factors on health (L. Davitz, *et al.*, 1977: Cartwright, 1976), are now thought to be necessary pre-conditions for planning effective nursing care. To respond to this demand appropriate learning experiences will have to be structured.

Hospital insulation

Apart from an elective period in the field of community nursing where the student works under the tutelage of the district nurse, most student nurses undertake all their training in hospital. Professional contact with the outside world is minimal and the three years' training takes place within a relatively sheltered environment. The hospital's tendency to insulate the nurse from knowledge about the social world of her patient results in limited information about the person in the patient. Additionally, the fact that any hospital is a complete and a complex community of its own while also being part of a wider community poses problems for the nurse whose working contract is strictly confined to geographical limits. The boundaries between hospital and its community are hardly ever crossed.

Nursing's popular image is always associated with hospitals. This is reflected in the huge painting hanging in the entrance hall of the Cardiff Royal Infirmary, painted in 1916 by Sir William James Thomas, depicting a Red Cross nurse in a Nightingale ward bandaging ever-so-gently the head wound of a suffering soldier. A 16th century woodcut of the Hotel Dieu in Paris shows women habited as nuns attending beds containing one or two patients. While the professional nurse is engaged apparently in relieving the physical suffering of the sick in hospital, a similar job at home is often carried out by mothers, wives and/or friends. This close, almost symbiotic relationship between nursing and hospital is deeply rooted historically for when physical institutions arise, somehow they have to be manned.

Lazar homes

Hospitals as we know them today have only been in existence since about the 18th century. Before that there were lazar homes, almshouses, orphanages, reformatories and similar institutions. People involved in giving care were invariably the inmates themselves. Nurses of the servant class, untrained, often lacking rudimentary education, carried out most of the work and nursing as such had apparently sunk to a low level.

Around the 1820s in Britain the first inkling of nursing reform was instituted with the introduction of some kind of disciplinary training. Between Miss Nightingale and her close ally, Sister Mary Jones, two different kinds of training schools were eventually set up. While Sister Mary Jones of the Anglican Nursing Sisterhood or the Sisterhood of St John the Evangelist started a training school for probationers, Miss Nightingale and Mrs Wardroper began a training for matrons at St Thomas's Hospital. After initial resistance, the breaking of new ground—the training of matrons and nurses—was finally accepted but not before doctors recognised nurses' merits when their worth was proved. Now demand for more trained nurses increased rapidly.

The vast extension of the 'voluntary' hospital building programme during the 18th century coupled with the discovery of anaesthesia and the development of the germ-theory in the 19th century laid the foundation for the practice of relatively safe hospital surgical procedures, and many of the newly trained nurses became proficient doctors' assistants. One reason for hospital nursing's predominance is thus fairly obvious. Sick people at home were looked after by their families. One other important reason for hospital predominance is probably attributable to the fact that nurse learners, trainees and trained personnel make up very largely the labour force in hospital which at one time included most

if not all of the domestic activities.

Professional nursing, heralded into the nineteenth century under the guidance of Miss Nightingale, Sister Mary Jones and others, was thus hospital based and medically dependent.

Accelerating rate of change

During a period when knowledge and the pattern of practice increase and change rapidly (Toffler, 1974), the responsibility of nurse tutors to provide a relevant curriculum is considerable. There is no doubt that educational changes required over time reflect prevailing economic, social and political conditions and particular group interests. Discussing nursing education in relation to curriculum content Chapman (1974) anticipates the development of a nursing approach which by negating compartmentalisation would 'be centred [instead] on patients whose progress and care is followed wherever it occurs from outpatients, admission, treatment by drugs and/or surgery, rehabilitation and back into the community'.

A nursing curriculum should be a dynamic response to two interrelated forces. One, the prevailing needs of the society, two to students' needs which can bridge the gap with the past and present and will envisage future requirements. It should be both balanced and comprehensive and should afford intellectual challenge. Its clinical relevance should be based on adequate scientific premises and it should encourage critical thinking about oneself and others. While these may remain pious hopes there are indicators from a number of nursing education departments in Britain of curriculum change in both content and direction.

The nurse and the patient's world

How does a nurse learn to make sense of her patient's social world so that its significance can be built into a plan of nursing care which is to benefit her patient? If she could provide herself with access to her patient's social world, she might develop an insight into her patient's concern which could well influence the therapeutic processes. This same insight might also contribute to a development of the nurse's own awareness about a reality of a social world which generally speaking is foreign to her.

The Department of Advanced Nursing Studies at the Welsh National School of Medicine has initiated a teaching and learning programme commonly referred to as the patient-link project. It has three main aims, the dynamic interaction of which compensates for the narrowness of each separate approach. While the overall aim is one of integration, its individual emphasis is broken down as follows:

1. integration between hospital and community
2. integration between theory and praxis
3. integration between cognitive and social learning experiences.

By focusing predominantly on the person in the patient, the nursing student links herself to a patient, his home and the hospital, meeting him wherever he takes up residence, temporarily or permanantly. By contacting the individual before he becomes a patient the student learns where and how he lives. The student can thus gain some knowledge of the patient's social relations, his congruence or lack of it with that of his social world, all of which are likely to affect the disease entity and to spell out for the student the meaning of illness for the patient. The student nurse should then become aware to what extent the patient's environment might be the cause of his disease (E. Bott, 1976) or likewise how the disease and the symptoms might affect the environment (Mann, 1975).

When the patient returns home, the visiting student nurse will investigate the relationship between the personality of the individual, the illness entity, the nature of hospital care and the patient's social environment. Seeing and meeting with prospective patients and his family or friends in his own home before hospital admission and after discharge should provide the student nurse with a variety of learning experiences which are difficult to convey by any other means.

At present the link-programme operates during the student's medical and surgical nursing experiences in his/her second undergraduate year. Thus the purely cognitive knowledge gained during this period is an amassing of facts about medicine, surgery and the appropriate nursing techniques. The link programme, by providing social learning experiences, fits this cognitive knowledge into context, highlighting relationships where appropriate.

At the end of the total experience the student together with her tutor will have explored a nursing care study which should incorporate all the relevent social factors believed to impinge on the development of nursing care plans and therefore ultimately on patient care.

The nursing student finds a patient from various sources: outpatient department's registrar, from the consultant's waiting list, from Sister's admission book or from the hospital's waiting list. Permission to visit is sought either by seeing the patient personally when attending outpatients or else by writing and asking for a reply in an enclosed self-addressed envelope. Home visiting can take place only at convenient times to all concerned, the student, the patient and the ward organisation. It is considered as a clinical component but experience over two years has shown—the time that the scheme has been in operation—that students spend over and above the clinical hours allotted to them.

Students answering questionnaires state that they not only do not mind spending additional time on the project but they positively seek to extend it. Patients too have expressed enthusiasm as to them the project indicates a concern over continuity of care. Home visits before admission can help students to anticipate the possible outcome of the patient's progress, having gained information about the patient's support system (family, friends), his socio-economic background and the likely cultural and psychological constraints which determine patients' responses to sickness. The visits following a stay in hospital could monitor progress and discrepancy, if any, between the advice and prescription given in hospital and its execution at home. It can also encourage the student to become aware of the need for constant re-assessment of situations.

Learning and teaching take place at two levels. The department's tutorial system enables individual tutors and students to discuss work in more detail, highlighting particular problems, and periodic group discussions draw together the varied experiences from students' peers which are now shared and thereby become common property. Bearing in mind Cook's (1954) conclusions that 'such teaching (small group discussion) is a calculated risk rather than a social panacea', care is taken to balance discussions with lectures and individual tutorials.

While the intention of the patient-link project during the period of nurse training and/or education is to facilitate social learning experiences, it can also generate ideas on different approaches to the organisation of nursing. As Chapman suggests: 'the care of the patient in his own home by the nurse who had cared for him in hospital would help prevent some of the problems of poor continuity of care as highlighted in *Home from Hospital*'.

'Social learning'

These possibilities apart one can now turn to a discussion of the term 'social learning' and consider to what extent, if any, student nurses are likely to

make sense of their patients' social world. Ultimately, we need to examine what use nurses could make of their social learning experiences.

Because social learning means many things to many men it is ambiguous and its use is therefore problematical. It needs to be examined in depth with the help of adequate research tools. Notwithstanding its ambiguity its limited usage has a place. Within educational establishments it was actively pursued during the heydays of the liberal studies movement in the 60s. Its ideology, hammerd out and refined in the Liberal Studies Departments of the various polytechnics in Great Britain was rooted in the idea that a narrowly conceived vocational apprentice training is not likely to produce a 'liberal' personality, capable of developing into a professional and a citizen (Bratschell, 1966). Therefore the training of apprentices, plumbers, electricians, hairdressers and others should be extended by an inclusion of liberal studies as part of their vocational training.

At the time, social learning experiences comprised two important dimensions both of which could well become part of an intellectual equipment of the future nurse. One is concerned with pedagogical criteria in addition to purely cognitive aspects of learning, the other is concerned with its political - counterpart, political education. Though these are considered separately, they constantly overlap social and political learning, at each phase of training and/or education.

Aspects of communication

The pedogogical aspect of social learning centres around the classroom where non-authoritarian teaching and learning attitudes are developed and emancipatory behaviour is stimulated among both students and teachers. It incorporates method, content and outcome. Its core concern is with all aspects of communication; language and its social context of a verbal and a non-verbal nature; empathy, the phenomenon to understand without becoming the significant other; the toleration of ambiguity itself as well as a toleration of the diversity of cultural differences; the disparate tendency of nurturing non-judgemental attitudes while developing an ability to adopt a critical stance when faced with unacceptable social and political situations.

In the area of political education social learning is considerd as the core concept integrating theory with praxis as when students together with their teachers explore each others' ideas in non-threatening situations. Here too, the concept includes method, content and outcome. When turning to nurse education it becomes apparent that traditional notions of neutrality and authority will make it difficult for nurse tutors to share personal views with their students. And Frankenstein (1963) supports the view that the needs of the individual cannot be explored if the professional working in the area of human guidance is not prepared to transcend his professional identity.

Breaking the barriers

Social learning in nurse education and practice could be used to open the way to break down those barriers and to seek knowledge together within a teaching and learning environment where knowledge becomes common property. If the personal views of students or tutors can be shared, explored and discussed students are likely to gain confidence in developing their own standpoint.

How are students to make sense of their patients' social world? Following ongoing sociological disputes between those who defend the objectivity of social reality and those who place subjectivity in the centre of their analyses, students will have to learn to make use of what critical analytical abilities they have and can develop. They will need to learn to draw on as varied as evidence as they can obtain before making judgements It is inevitable that students start out by viewing the world from a perspective-based knowledge of reality. The emancipatory approach learnt during the period of social experience should be a prerequisite to the gaining of adequate social knowledge. But ultimately it does depend on interpretation. The small critical group discussion approach should help to widen those perspectives.

There is a danger that in encouraging students to go out and amass social facts they overstep their role and pry into the private lives of potential patients which will be resented. On the other hand, by ignoring relevant social facts patient care planning will be guilty of negligence. Care must surely be taken to emphasise the nature and type of priority of such social knowledge which is deemed to be essential for effective nursing care planning. There is no place for obtaining information which is not relevant and the supervisory role of the individual tutor can act as the control mechanism.

The Baby-link

The patient-link project builds upon another home/hospital linked programme, the Baby-link (Ferguson, 1975) which operates during the students' first year undergraduate work and introduces them to a potential healthy family with a newborn baby. This programme is centred around a course in child growth and development and ostensibly its aim is to observe and follow the development of a newborn from 0-6 months. But it also introduces the student to the social world of potential patients.

The social learning experiences of these two programmes enable the students to move comfortably in and out of hospital into the community without a role contortion each time they exchange their uniforms with blue jeans. By considering the relevant factors of the social world of the patient nursing care planning should become more realistic in relation to patients' needs. Simultaneously, by learning about the reality of the social world of prospective patients student nurses' awareness of the relationship between illness and social, economic and political factors should become sharpened to the point of shedding traditional neutrality.

The way to change is now open.

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Council of the European Commuities

Council Directive **(77/453/EEC)**

of 27 June 1977 concerning the co-ordination of provisions laid down by law, regulation or administrative action in respect of the activities of nurses responsible for general care

The articles and the annex

Article 1

1. Member States shall make the award of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care as specified in Article 3 of Directive 77/452/EEC subject to passing an examination which guarantees that during his training period the person concerned has acquired:

(*a*) adequate knowledege of the sciences on which general nursing is based, including sufficient understanding of the structure, physiological functions and behaviour of healthy and sick persons, and of the relationship between the state of health and the physical and social environment of the human being;

(*b*) sufficient knowledge of the nature and ethics of the profession and of the general principles of health and nursing;

(*c*) adequate clinical experience; such experience which should be selected for its training value, should be gained under the supervision of qualified nursing staff and in places where the number of qualified staff and equipment are appropriate for the nursing care of the patients;

(*d*) the ability to participate in the practical traiing of health personnel and experience of working with such personnel;

(*e*) experience of working with members of other professions in the health sector.

2. The training referred to in paragraph 1 shall include at least:

(*a*) a general school education of 10 years' duration attested by a diploma, certificate or other formal qualification awarded by the competent authorities or bodies in a Member State, or a certificate resulting from a qualifying examination of an equivalent standard for entrance to a nurses' training school;

(*b*) full-time training, of a specifically vocational nature, which must cover the subjects of the training programme set out in the Annex to this Directive and comprise a three-year course or 4 600 hours of theoretical and practical instruction.

3. Member States shall ensure that the institution training nurses is responsible for the co-ordination of theory and practice throughout the programme.

The theoretical and technical training mentioned in part A of the Annex shall be balanced and coordinated with the clinical training of nurses mentioned in part B of the same Annex in such a way that the knowledge and experience listed in paragraph 1 may be acquired in an adequate manner.

Clinical instruction in nursing shall take the form of supervised in-service training in hospital departments or other health services, including home nursing services, approved by the competent authorities or bodies. During this training student nurses shall participate in the activities of the departments concerned in so far as those activities contribute to their training. They shall be informed of the responsibilities of nursing care.

4. Five years at the latest after notification of this Directive and in the light of a review of the situation, the Council, acting on a proposal from the Commission, shall decide whether the provisions of paragraph 3 on the balance between theoretical and technical training on the one hand and clinical training of nurses on the other should be retained or amended.

5. Member States may grant partial exemption to persons who have undergone part of the training referred to in paragraph 2 (b) in the form of other training which is of at least equivalent standard.

Article 2

Notwithstanding the provisions of Article 1, Member States may permit part-time training under conditions approved by the competent national authorities.

The total period of part-time training may not be shorter than that of full-time training. The standard of the training may not be impaired by its part-time nature.

Article 3

This Directive shall also apply to nationals of Member States who, in accordance with Council Regulation (EEC) No 1612/68 of 15 October 1968 on freedom of movement for workers within the Community, are pursuing or will pursue, as employed persons, one of the activities referred to in Article 1 of Directive 77/452/EEC.

Article 4

1. Member States shall bring into force the measures necessary to comply with this Directive within two years of its notification and shall forthwith inform the Commission thereof.

2. Member States shall communicate to the Commission the texts of the main provisions of national law which they adopt in the field covered by this Directive.

Article 5

Where a Member State encounters major difficulties in certain fields when applying this Directive, the Commission shall examine these difficulties in conjunction with that State and shall request the opinion of the Committee of Senior Officials on Public Health set up by Decision 75/365/EEC, as amended by Decision 77/455/EEC.

Where necessary, the Commission shall submit appropriate proposals to the Council.

Annex

Training programme for nurses responsible for general care

The training leading to the award of a diploma, certificate or other formal qualification of nurses responsible for general care shall consist of the following two parts:

A. Theoretical and technical instruction:

(a) *nursing:*
nature and ethics of the profession,
general principles of health and nursing,
nursing principles in relation to:
— general and specialist medicine,
— general and specialist surgery,
— child care and paediatrics,
— maternity care,
— mental health and psychiatry,
— care of the old and geriatrics;

(b) *basic sciences:*
anatomy and physiology,
pathology,
bacteriology, virology and parasitology,
biophysics, biochemistry and radiology,
dietetics,
hygiene:
— preventive medicine,
— health education,
pharmacology;

(c) *social sciences:*
sociology,
psychology,
principles of administration,
principles of teaching,
social and health legislation,
—legal aspects of nursing.

B. Clinical instruction:

Nursing in relation to:
— general and specialist medicine,
— general and specialist surgery,
— child care and paediatrics,
— maternity care,
—mental health and psychiatry,
— care of the old and geriatrics,
— home nursing.